Pomerance Eye Center
Patient Information Sheet

Date_____ Patient Name_____
First, Middle Initial, Last

Address_____ _____ _____
Street City, State Zip Code

Phone: Home (____)_____ Work (____)_____ Other (____)_____

Date of Birth_____ Social Security Number_____ Sex_____

Marital Status (check one) ___Single ___Married ___Divorced ___Separated ___Widow

Employer's Name_____ Address_____

Employment Status (check one) ___Full Time ___Part Time ___Student ___Unemployed ___Retired

E-Mail Address_____ Referred by:_____

How did you hear about our practice?_____

Who is your Primary Care Physician?_____ _____
Name Address

Name of your preferred pharmacy _____ _____
Name Address/Phone #

Primary Insurance Carrier _____ Address _____
Insured's Name _____ Relationship to Patient _____
Insured's Date of Birth_____ Insured's Social Security Number_____
Insurance I.D. Number_____ Group Number_____

Secondary Insurance Carrier _____ Address _____
Insured's Name _____ Relationship to Patient _____
Insured's Date of Birth_____ Insured's Social Security Number_____
Insurance I.D. Number_____ Group Number_____

Responsible Party _____ Date of Birth_____
Relationship to Patient _____ Social Security Number_____
Address_____
Phone Number (____)_____ Employer's Name_____
Employer's Address_____

Emergency Contact: Name_____
Address_____ Home Phone (___)_____
Relationship_____ Other Phone (___)_____

Is Patient's condition related to an accident?___Yes ___No Date of Accident_____
Type of accident ___Auto ___Employment ___Other If other, please explain_____

I have completed this form fully and certify that I am the patient or duly authorized general agent of the patient. I understand even though I have insurance coverage, I am responsible for payment of services.

_____ _____
Signature of Patient, Parent or Responsible Party Date

Pomerance Eye Center, PC

_____
Patient Name

1. General Consent for Treatment: I consent to treatment by Pomerance Eye Center, PC physicians and staff for my eye care, including but not limited to testing, medications, and minor procedures. I acknowledge and agree that NO GUARANTEES have been made to me as to the results or outcome of my eye care. I understand that State Law requires physicians to report certain communicable diseases to the Health Department.

2. Authorization to Release Medical Information: I authorize Pomerance Eye Center, PC and all physicians involved in my care to disclose and release my medical information needed to process a claim to my insurance companies. I authorize the provider to act as my agent in helping me obtain payment from my insurance companies. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a monthly statement for any balance due by me.

3. Supplemental Insurance Assignment Authorization: Insurance Company_____
   Policy #_____

   A Supplemental Insurance or Medigap policy is a health insurance policy or other health benefit plan, offered by a company to those entitled to Medicare benefits. It is designed to pay certain costs that Medicare does not pay. I request that payment of authorized Supplemental Insurance or Medigap benefits be made on my behalf to Pomerance Eye Center, PC for any services furnished me by the physician/supplier. I authorize any holder of medical information about me to release any information needed to determine these benefits.

_____ _____
Signature of Secondary Insurance Policyholder Date

Assignment of Insurance Benefits/Promise to Pay: For and in consideration of services rendered and to be rendered by Pomerance Eye Center, PC, I hereby guarantee payment for all charges incurred for the account of the above named patient. I understand and direct any person, firm or corporation, including but not limited to, insurance companies or attorneys representing the patient or any other party, for such services, to assign proceeds of any payment for services rendered to said patient directly to Pomerance Eye Center, PC. I understand that by Pomerance Eye Center, PC accepting assignment of benefits, the provider does not relinquish its right to collect any balance not paid by any third party. Payment for annual deductibles and co-payments are due and collectable at the time of service. If we have not received a response from your insurance carrier within 45 days from the date the claim is filed, the balance will be transferred to patient responsibility status. Once the balance is transferred to patient responsibility and if it is not paid in full within 30 days, a rebilling fee will be added each month until the account is paid in full. I further agree that if such indebtedness is placed in the hand of a collector or attorney for collection, I will pay collection fees and attorney fees, interest, court costs and other collection expenses.

I have read and understand this document, and agree to its terms.

_____ _____ _____
Patient/Authorized Party Relationship Date

_____
Witness

POMERANCE EYE CENTER, P.C.
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that I have received a copy of this notice.
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

Signed by: _____
Patient

Witness:_____

Date:_____

POMERANCE
eye center pc

Information and Consent for Refractions

A refraction is the determination of the prescription needed for glasses or contact lenses. It is not considered a part of the definition of a complete or comprehensive eye examination by most insurers and is therefore considered a "vision service" and not a "medical" service.

Major medical insurance companies do not pay for a non-covered service. Insurance companies consider the provision of a written prescription for glasses a separate and distinct service. If you have a "vision" plan and if we provide services under your "vision" plan, we will bill your insurance.

The fee for a refraction must be collected from the patient in addition to any co-payment, co-insurance, or deductible amounts your plan may require. Our charge for refraction is $60.00 under your vision plan. When paid at the time of service, our fee is $25.00. We will only bill the refraction to your insurance company when we are sure it is a covered benefit under your vision plan.

Patient Consent:
I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service and understand that payment, ($25.00) is due at the time of service. I understand any co-payment, co-insurance, or deductible amounts I may have are separate from and NOT included in the refraction fee.

_____ _____

Patient Name (Printed) Date

_____ _____

Patient Signature (or person authorized to sign for patient) Witness

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eye center pc

Information and Consent for Dilated Eye Exam

Patient Name_____ DOB_____

Dilating eye drops are used to enlarge the pupils of the eye to allow the physician to obtain a better view of the inside of your eyes. Not every examination will require dilation.

Dilation can take 20 to 40 minutes, which varies from person to person, and can last 3 to 6 hours or longer in some patients. Dilating drops can temporarily blur your vision, especially your near vision, and make bright lights bothersome. It is not possible for us to predict to what degree your vision will be affected. Driving may be difficult immediately after your examination. If you are concerned about these problems, you may wish to make alternative transportation arrangements, although a large number of patients drive after dilation with the assistance of temporary sunglasses and reversal drops, which we will provide after your dilation.

Adverse reactions from dilating drops are rare but possible. These may include allergy and elevated pressure. There is no better place to have such a reaction than in front of your doctor.

The undersigned hereby authorizes the physician and/or physician extender to administer dilating eye drops. The undersigned acknowledges the dilating drops are necessary to perform a complete exam of the eye which aids the physician in revealing any serious conditions.

This consent is permanent unless withdrawn in writing by the undersigned.

I consent to having dilating drops placed in my eyes as needed by the physician.

_____ _____

Patient Signature (or person authorized to sign for the patient) Date

I decline to have dilating drops.

_____ _____

Patient Signature (or person authorized to sign for the patient) Date